

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2011
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/25/2011
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NAME OF PROVIDER OR SUPPLIER

NORRIS HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3382 ANDERSONVILLE HIGHWAY
ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician related to</p>	F 157	<p>F157</p> <p>HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #14 had her J tube replaced after the MD was notified on 5/24/11. Resident was taking PO diet as well.</p> <p>Resident #14 is no longer at this facility.</p> <p>HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All residents with enteral feedings have the Potential to be affected.</p> <p>The facility identified 12 residents that have enteral feedings.</p> <p>Those residents identified with enteral feedings were assessed on May 25, 2011 and again on June 6, 2011 to ensure the tubes were patent.</p>	6/24/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157 Continued From page 1
a clogged feeding tube for one (#14) resident of
nineteen residents reviewed.

The findings included:

Resident #14 was admitted to the facility on May
12, 2011, with diagnoses including Aortic
Stenosis, Hypertension, Diabetes, Ulcerative
Colitis, and History of Bowel Resection.

Medical record review of the physician's orders
dated May 12, 2011 through May 31, 2011,
revealed, "...Diet: Reg (regular) a food tray for
pleasure eating...Tube Feeding ...Pivot (name of
the nutritional tube feeding) 1.5 (at) 65 cc/hr
(hour)..."

Medical record review of the nursing note dated
May 21, 2011, revealed, "...5A (a.m.)...In room
most of shift d/t (due to) peg (percutaneous
endoscopic gastrostomy) tube being stopped up.
Unable to unclog tube. Will pass on to next
shift...4:30 p (p.m.)...Peg tube not patent...will
cont (continue) to observe..."

Medical record review of the nursing note dated
May 22, 2011, revealed, "...6 PM...Peg tube not
patent..."

Medical record review of the nursing note dated
May 24, 2011, revealed, "...12 A J tube clogged
unable to unclog spoke (with) Dr. on call new
orders received..."

Medical record review of a physician's order
dated May 24, 2011, 12:00 a.m., revealed,
"...Hold TF (tube feeding) give meds po (by
mouth) (and) clamp...tube x 2 (hours) till NP

F 157 WHAT MEASURES WILL BE PUT
INTO PLACE OR SYSTEMIC
CHANGES MADE TO ENSURE
THAT THE DEFICIENT PRACTICE
WILL NOT RECUR?

The Director of Nursing conducted an in-
service regarding MD notification of
changes, including clogged enteral
feeding tubes for the Licensed Nurses on
June 1-2, 2011 and is on-going until all
nurses have completed the in-service. All
nurses were in-serviced except 7 as of June
6, 2011. Those nurses will not be allowed
to work until the in-service education is
completed.

A daily clinical meeting will be conducted
(M-F) by the DON, ADON, and Unit
Managers that will include reviewing the
24 hr report as well as the new MD
orders. If during this daily clinical
meeting issues are observed that a
situation requiring MD notification and
the notification was not done, then DON,
ADON or Unit Manager will notify the
MD and additional in-service education
will be provided to that individual nurse.

The DON/ADON or Unit Manager will
audit 5 change in clinical condition
situations weekly for 4 weeks then
monthly for 2 months to ensure MD
notification occurred.

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F 157	Continued From page 2 (nurse practitioner) can eval (evaluate) J tube... Medical record review of the physician's progress note dated May 24, 2011, revealed, "...Asked by nurse to eval. Pt. (patient) for obstructed J-tube...Multiple staff members have attempted to clear the obstruction to no avail...contacted (named) ER (emergency room (and) GI (gastrointestinal) lab (and) was told to contact special procedures...scheduled pt for 1 pm tomorrow..." Interview on May 25, 2011, at 8:10 a.m., with the Director of Nursing, in the conference room, confirmed the physician was not notified timely of the obstructed J-tube.	F 157	HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? The DON or Unit Managers to determine if the system is working will review results of the weekly random audits of Change in Clinical conditions. If issues are identified then modification will be made via the QAA committee. The QAA committee will review these audits monthly for 3 months.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? Resident #4 was reassessment by the Unit Manager on June 3, 2011 to include Braden Scale, Pre-Physical restraint, Resident Transfer, Pain, Fall risk and Bowel and Bladder. His Care plan was updated on June 3, 2011 by the Unit Manager to include his current clinical needs.	6/24/11

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F 279	<p>Continued From page 3 under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility, failed to review and revise a comprehensive plan of care to meet the resident's medical and nursing needs for one resident (#4) of nineteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #4 was admitted to the facility December 17, 2010, with diagnoses including Traumatic Brain Injury, Chronic Respiratory Failure, Chronic Anemia, Contractures, Malnutrition, Quadriplegia (paralysis of all four limbs and usually the trunk), Peg Tube (percutaneous endoscopic gastrostomy tube, feeding tube), Pressure Sores, and Tracheostomy (surgically created airway in the neck for breathing).</p> <p>Medical record review of the Minimum Data Set dated May 13, 2011, revealed the resident had no speech, had severely impaired cognitive skills, had five ongoing pressure sores, and was totally dependent on staff for all activities of daily living.</p> <p>Medical record review of the Care Plan dated May 13, 2011, revealed "At Risk for Fluid Deficit ...Place fluids at bedside in resident's reach...Pain/Discomfort...will verbally express increased satisfaction with pain control...health maintenance altered...Keep items in reach and remind res (resident) of placement of objects..."</p>	F 279	<p>HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All residents have the potential to be affected by this practice.</p> <p>The facility has 4 hallways- each week the residents residing on one particular hall will be reviewed to ensure Care Plans are current to the resident needs. One hallway will be reviewed weekly until the entire facility has been reviewed.</p> <p>WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The Licensed Nurses were in-serviced by the DON on 6/1 and 6/2/11 regarding the Care Plan process and documenting appropriate interventions that support the needs for those particular residents.</p> <p>The MDS nurses were in-serviced on June 3, 2011 by the Regional MDS nurse regarding Care Plan process being specific for the residents needs.</p> <p>MDS nurses, DON or Unit Managers will audit up to 5 resident each week times 4 weeks then monthly times 2 months to determine if the appropriate Care Plans are in place.</p>	

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F 279	Continued From page 4 Observation on May 24, 2011, at 8:55 a.m., revealed the resident resting on the right side non-responsive to voice, with tube feeding infusing through a PEG tube, oxygen provided through a tracheostomy site, urinary catheter, and contracted legs, arms, and hands. Interview with the Director of Nursing, in the conference room, May 25, 2011, at 8:05 a.m., confirmed the current care plan had not been reviewed and revised to reflect the resident's current assessment and to meet the resident's needs.	F 279	HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? Results of the 5 random audits will be presented to the monthly QAA committee for review. If identified issues are determined then adjustments to the plan of correction will be made. QAA committee will monitor this for 3 months or longer depending if this plan is successful.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? Resident #15 was re assessed by the FNP on May 25, 2011 and the Fluid restrictions was discontinued. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? Residents who require fluid restrictions have the potential to be affected by this practice.	6/24/11

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F 280	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and interview, the facility failed to develop the care plan to include fluid restrictions for one (#15) of nineteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #15 was admitted to the facility on May 13, 2011, with diagnoses including End Stage Renal Disease, Diabetes, Cerebrovascular Accident with Left Hemiparesis, and Congestive Heart Failure.</p> <p>Medical record review of a Nurse Practitioner's (NP) order dated May 20, 2011, revealed "...Fluid restriction 1000 cc/day..."</p> <p>Medical record review of the Interim Care Plan dated May 13, 2011, revealed no documentation to address the resident's need for fluid restriction.</p> <p>Interview on May 24, 2011, at 3:25 p.m., with Certified Nursing Assistant (CNA) #1 (CNA responsible for the resident's care), at the nursing station, revealed CNA #1 was not aware of the resident's need for fluid restriction.</p> <p>Interview on May 24, 2011, at 4:30 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the care plan was not developed to include the fluid restriction.</p>	F 280	<p>The facility currently has 4 residents on fluid restrictions. Those residents have parameters in place to reflect the current MD orders and Intake is being monitored.</p> <p>WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The RD, DON, ADON and Unit Managers were in-serviced by the Administrator on 6/6/2011 regarding the expectations of having care plans in place for fluid restrictions, Intake being monitored.</p> <p>The Licensed Nurses and Resident Care Specialist (nursing assistants) were in-serviced by the DON on June 1-2, 2011 and ongoing until all have completed the in-service education regarding the facility protocol for residents with fluid restrictions. This in-service education will continue until we complete the in-service for all Licensed Nurses and Nursing Assistants.</p> <p>Calculations for the residents with fluid restrictions were completed by the DON on May 24, 2011. This calculation involves the amount of fluid to be served</p>		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p>	F 281	<p>during each meal tray, each med pass and the available fluid for each shift.</p> <p>The fluid calculations were added to the ADL Kardex for the nursing assistants to utilize.</p>		

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445303

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B. WING

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DEFICIENCY)

(X5)
COMPLETION
DATE

F 280

Continued From page 5

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to develop the care plan to include fluid restrictions for one (#15) of nineteen residents reviewed.

The findings included:

Resident #15 was admitted to the facility on May 13, 2011, with diagnoses including End Stage Renal Disease, Diabetes, Cerebrovascular Accident with Left Hemiparesis, and Congestive Heart Failure.

Medical record review of a Nurse Practitioner's (NP) order dated May 20, 2011, revealed "...Fluid restriction 1000 cc/day..."

Medical record review of the Interim Care Plan dated May 13, 2011, revealed no documentation to address the resident's need for fluid restriction.

Interview on May 24, 2011, at 3:25 p.m., with Certified Nursing Assistant (CNA) #1 (CNA responsible for the resident's care), at the nursing station, revealed CNA #1 was not aware of the resident's need for fluid restriction.

Interview on May 24, 2011, at 4:30 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the care plan was not developed to include the fluid restriction.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET
SS=D PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

F 280

Intake records were implemented on May 24, 2011 for the residents identified with fluid restrictions.

A weekly audit by the DON, RD or Unit Managers for the residents with fluid restrictions will be completed for 4 weeks then 2 months to determine if the MD orders are being followed and included on the ADL kardex.

HOW WILL THE FACILITY
MONITOR ITS CORRECTIVE
ACTIONS TO ENSURE THAT THE
DEFICIENT PRACTICE WILL NOT
RECUR?

The RD, Unit managers and the DON will present the results of the audits to the QAA committee for 3 months. If issues are identified then modifications to the plan of correction will be made.

F281

HOW WILL CORRECTIVE ACTION
BE ACCOMPLISHED FOR THOSE
RESIDENTS FOUND TO HAVE
BEEN AFFECTED BY THE
DEFICIENT PRACTICE?

Resident #15 was re assessed by the FNP on May 25, 2011 and the Fluid restrictions was discontinued.

F 281

4/24/11

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F 281	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to follow Nurse Practitioner's orders for a fluid restriction for one (#15) of nineteen residents reviewed. The findings included: Resident #15 was admitted to the facility on May 13, 2011, with diagnoses including End Stage Renal Disease, Diabetes, Cerebrovascular Accident with Left Hemiparesis, and Congestive Heart Failure. Medical record review of a Nurse Practitioner's (NP) order dated May 20, 2011, revealed "...Fluid restriction 1000 cc/day..." Medical record review revealed no documentation of the total daily fluid intake for the resident. Review of the facility's policy Fluid Restrictions revealed "Purpose-To ensure resident ordered fluid restrictions receive the proper allocation...Fluid restrictions are coordinated between Dietary Department and Nursing Services. Diets and beverage preferences are adjusted to comply with fluid restriction physician orders...Upon notification of a fluid restriction physician order, the Dietary Manager meets with the Charge Nurse to determine the amount of total fluid that will be provided by each department...The fluid restriction is entered into the dietary software, noted on the tray ticket and snack labels, and clearly identified the type and	F 281	HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? Residents who require fluid restrictions have the potential to be affected by this practice. The facility currently has 4 residents on fluid restrictions. Those residents have parameters in place to reflect the current MD orders and Intake is being monitored. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? The RD, DON, ADON and Unit Managers were in-serviced by the Administrator on 6/3/2011 regarding the expectations of having care plans in place for fluid restrictions, Intake being monitored. The Licensed Nurses and Resident Care Specialist (nursing assistants) were in-serviced by the DON on June 1-2, 2011 and is ongoing until all have completed the in-service education, regarding the facility protocol for residents with fluid restrictions. This in-service education will continue until we complete the in-service for all Licensed Nurses and Nursing Assistants.	

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F 281	Continued From page 7 amount of fluids to be served." Interview on May 24, 2011, at 3:25 p.m., with Certified Nursing Assistant (CNA) #1 (CNA responsible for the resident's care), at the nursing station, revealed CNA #1 was not aware of the resident's need for fluid restriction. Interview and review of the resident's current food tray tickets, on May 24, 2011, at 4:15 p.m., with the Registered Dietician (RD), at the 400 hall nursing station, revealed no documentation of the fluid restriction on the resident's current tray ticket, and confirmed the dietary department was unaware of the order for the fluid restriction. Interview on May 25, 2011, at 8:40 a.m., with the Director of Nursing (DON), in the office, revealed there was no documentation of the resident's total fluid intake, and confirmed the NP's orders were not followed.	F 281	The DON on May 24, 2011 completed calculations for the residents with fluid restrictions. This calculation involves the amount of fluid to be served during each meal tray, each med pass and the available fluid for each shift. The fluid calculations were added to the ADL Kardex for the nursing assistants to utilize. Intake records were implemented on May 24, 2011 for the residents identified with fluid restrictions. A weekly audit by the DON, RD or Unit Managers for the residents with fluid restrictions will be completed for 4 weeks then 2 months to determine if the MD orders are being followed and included on the ADL kardex.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow the care plan developed for one resident (#4) of nineteen residents reviewed. The findings included:	F 282	HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? The RD, Unit managers and the DON will present the results of the audits to the QAA committee for 3 months. If issues are identified then modifications to the plan of correction will be made.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/11
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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

445303

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

05/25/2011

NAME OF PROVIDER OR SUPPLIER

NORRIS HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3382 ANDERSONVILLE HIGHWAY
ANDERSONVILLE, TN 37705

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5)
COMPLETION
DATE

F 282 : Continued From page 8

Resident #4 was admitted to the facility December 17, 2010 with diagnoses including Traumatic Brain Injury, Chronic Respiratory Failure, Chronic Anemia, Contractures, Malnutrition, Quadriplegia (paralysis of all four limbs and usually the trunk), Peg Tube (percutaneous endoscopic gastrostomy tube, feeding tube), Pressure Sores, and Tracheostomy (surgically created airway in the neck for breathing).

Medical Record review of the resident's Plan of Care dated May 13, 2011, revealed "...At Risk for Fluid Deficit...Approach...Intake and output q (every) shift...". Further medical record review of Medication Administration Records and resident's chart revealed no documentation of fluid intake and output monitoring

Interview with the Director of Nursing in the conference room on May 25, 2011, at 8:05 a.m., confirmed the facility staff had not monitored fluid intake and output for the resident per the current Plan of Care.

F 315 483.25(d) NO CATHETER, PREVENT UTI,
SS=D RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

F 282

F282

HOW WILL CORRECTIVE ACTION
BE ACCOMPLISHED FOR THOSE
RESIDENTS FOUND TO HAVE
BEEN AFFECTED BY THE
DEFICIENT PRACTICE?

Resident #4 has had his care plan updated to reflect no Intake & output. On June 3, 2011 by the Unit Manager.

HOW WILL THE FACILITY
IDENTIFY OTHER RESIDENTS
HAVING THE POTENTIAL TO BE
AFFECTED BY THE SAME
DEFICIENT PRACTICE?

Residents who have Enteral feedings have the potential to be affected by this practice.

The facility currently has 12 residents with enteral feedings. These residents care plans were reviewed to ensure the Care Plan is appropriate for the interventions being provided.

The facility currently has 1 resident requiring Intake and Output.

WHAT MEASURES WILL BE PUT
INTO PLACE OR SYSTEMIC
CHANGES MADE TO ENSURE
THAT THE DEFICIENT PRACTICE
WILL NOT RECUR?

6/24/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/25/2011
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NAME OF PROVIDER OR SUPPLIER

NORRIS HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3382 ANDERSONVILLE HIGHWAY
ANDERSONVILLE, TN 37705

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F 282	Continued From page 8 Resident #4 was admitted to the facility December 17, 2010 with diagnoses including Traumatic Brain Injury, Chronic Respiratory Failure, Chronic Anemia, Contractures, Malnutrition, Quadriplegia (paralysis of all four limbs and usually the trunk), Peg Tube (percutaneous endoscopic gastrostomy tube, feeding tube), Pressure Sores, and Tracheostomy (surgically created airway in the neck for breathing). Medical Record review of the resident's Plan of Care dated May 13, 2011, revealed "...At Risk for Fluid Deficit...Approach...Intake and output q (every) shift...". Further medical record review of Medication Administration Records and resident's chart revealed no documentation of fluid intake and output monitoring. Interview with the Director of Nursing in the conference room on May 25, 2011, at 8:05 a.m., confirmed the facility staff had not monitored fluid intake and output for the resident per the current Plan of Care.	F 282	Licensed nurses were in-serviced on June 1-2, 2011 and Ongoing until all are completed by the DON regarding the need to complete Intake and Output for those residents identified as well as the need to review the care plans for residents to include appropriate interventions for each resident (if resident is bed bound- not include items to be placed in reach, if on fluid restriction- not to include place water pitcher at bedside) MDS nurses and the DON, ADON and Unit Managers were in-serviced on June 3, 2011 by the Administrator regarding the implementations of appropriate interventions such as items being in reach for residents that are able to reach and obtain those items. The DON, ADON, Unit Managers and the MDS nurses will audit 5 charts weeks to determine if the interventions are appropriate for the resident. These audits will occur for 4 weeks then monthly for 2 months.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? Results of the audits will be presented to the monthly QAA committee for 3 months. If issues are identified then modifications will be made and audits will continue.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

NORRIS HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
3382 ANDERSONVILLE HIGHWAY
ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure medical justification for the continued use of a urinary catheter for one (#14) of nineteen residents reviewed. The findings included: Resident #14 was admitted to the facility on May 12, 2011, with diagnoses including Aortic Stenosis, Hypertension, Diabetes, Ulcerative Colitis, and History of Bowel Resection. Medical record review of the physician's orders dated May 12, 2011, through May 31, 2011, revealed, "...F/C (urinary catheter) care q (every) shift (and) prn (as needed) (change) F/C q month..." Observation on May 25, 2011, at 7:45 a.m., revealed the resident lying on the bed with a urinary catheter to a bedside drainage bag. Interview on May 25, 2011, at 8:35 a.m., with the Nurse Practitioner, in the conference room, confirmed there was no medical justification for the continued use of the urinary catheter.	F 315	F315 HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? Resident #14- Was reviewed by the Medical Director and a new Dx was added to include Neurogenic Bladder secondary to extensive abdominal surgery causing incomplete bladder emptying. Resident #14 is no longer a resident at Norris Health and Rehab. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? The residents currently utilizing urinary catheters are at risk for this practice. The facility currently has 7 residents utilizing urinary catheters. All these residents have been evaluated to determine if the appropriate medical justification is in place.	6/24/11
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER NORRIS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure medical justification for the continued use of a urinary catheter for one (#14) of nineteen residents reviewed. The findings included: Resident #14 was admitted to the facility on May 12, 2011, with diagnoses including Aortic Stenosis, Hypertension, Diabetes, Ulcerative Colitis, and History of Bowel Resection. Medical record review of the physician's orders dated May 12, 2011, through May 31, 2011, revealed, "...F/C (urinary catheter) care q (every) shift (and) prn (as needed) (change) F/C q month..." Observation on May 25, 2011, at 7:45 a.m., revealed the resident lying on the bed with a urinary catheter to a bedside drainage bag. Interview on May 25, 2011, at 8:35 a.m., with the Nurse Practitioner, in the conference room, confirmed there was no medical justification for the continued use of the urinary catheter.	F 315	The Licensed Nurses were in-serviced on 6/1-2/2011 and on-going until all are completed by the DON on the need to ensure residents admitted with urinary catheters have medical justification for the catheters use. The DON, ADON, Unit Managers were in-serviced by the Administrator on the expectation that during the Daily Clinical Meeting (M-F) new admits will be reviewed and if they are admitted with urinary catheters there must be medical justification for the catheter use. If no medical justification then the MD must be notified and consultation for the necessity discussed for the catheter usage. A weekly random audit for 4 weeks then monthly for 2 months by the DON, ADON or Unit Managers of 5 new admits will be completed (if 5 admits with catheters occur each week) to determine if the medical justification for the catheters are in place. If the medical justification is not in place then the MD will be consulted and appropriate interventions to address the issues identified will occur. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	Results of the random audits will be presented to the monthly QAA committee for 3 months. If identified issues are noted then modifications to this plan of correction will be made.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

NORRIS HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3382 ANDERSONVILLE HIGHWAY
ANDERSONVILLE, TN 37705

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F 371	<p>Continued From page 10</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to follow proper hand-washing, and sanitary food preparation and storage to maintain safe food handling practices.</p> <p>The findings included:</p> <p>Observation on May 23, 2011, during the initial tour, beginning at 6:04 a.m., with the facility cook, in the dietary department, revealed the following:</p> <p>The cook went to the hand-washing station, in the kitchen, washed the hands, and found the paper towel dispenser empty. The cook proceeded through the kitchen, fanning the hands to dry. The cook requested housekeeping refill the paper towel dispenser. The cook did not return to the sink to properly re-wash the hands after paper towel dispenser had been filled.</p> <p>Review of the facility's food handling policy revealed "...2. Practice good personal hygiene...wash hands regularly....and dry with paper towels ..."</p> <p>Interview with the cook, at the time of the observation, confirmed that the facility's hand washing policy had not been followed.</p>	F 371	<p>F371</p> <p>HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>The Dietary staff has all been in-serviced on proper hand washing technique. Paper towels were replaced in the dispenser.</p> <p>Scouring pads and cleaning cloths were removed and stored in the appropriate place.</p> <p>The plastic bins have been ordered on June 3, 2011 to replace the ones with inappropriate fitting lids.</p> <p>The ham and Tofu were thrown out.</p> <p>HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>Any area within the facility has the potential for paper towels not to be in place.</p> <p>WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The Dietary staff was in-serviced on proper hand washing technique on May 31, 2011 and June 3, 2011 by the Dietary Manager.</p>	6/24/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE

**3382 ANDERSONVILLE HIGHWAY
ANDERSONVILLE, TN 37705**

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F 371	<p>Continued From page 11</p> <p>Continued observation of the dietary department, during initial tour on May 23, 2011, revealed the following:</p> <ol style="list-style-type: none"> 1. Scouring pads and cleansing cloths stored on a food prep table where toast was being prepared for breakfast. 2. Plastic bins, used for storage of dry beans, dry cereal, and sugar with lids that did not fit properly. 3. Plastic container with dry cereal contained debris: cereal crumbs and onion peels. 4. Red food coloring on the storage shelves without a lid. 5. The reach in cooler in the kitchen contained: <ol style="list-style-type: none"> a. ham in a small zip lock bag with no opened or use by date b. tofu stored in a small plastic container with a lid that did not close properly. <p>Review of the facility policy for food storage revealed"...5. Store cleaning supplies away from food storage and preparation areas...7. Store foods in clean, dry containers with tight fitting lids to prevent contamination...6. Date and label all products removed from original containers/packaging..."</p> <p>Interview with the Dietary Manager, in the dietary department, on May 23, 2011, at 9:20 a.m., confirmed the facility policies on hand hygiene and food storage had not been followed.</p>	F 371	<p>The dietary staff was in-serviced on proper storage of cleaning cloths and scouring pads on May 31, 2011 and June 3, 2011 by the Dietary Manager.</p> <p>The dietary staff was in-serviced on dating food placed in the refrigerator on May 31, 2011 and June 3, 2011 by the Dietary Manager.</p> <p>A daily audit for Sanitation checklist, handwashing and storage of cleaning supplies and equipment along with dating of food has been implemented (M-F) by the Dietary Manager and the assistant manager on May 31, 2011.</p> <p>Plastic bins have been order to replace the ones with ill-fitting lids on June 3, 2011.</p> <p>HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>Results of the daily (M-F) audits will be presented to the QAA committee monthly times 3 months. If identified issues are noted then modifications will be made to this plan of correction.</p>	
F 372 SS=B	<p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p>	F 372		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/25/2011
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NAME OF PROVIDER OR SUPPLIER

NORRIS HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
3382 ANDERSONVILLE HIGHWAY
ANDERSONVILLE, TN 37705

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F 372 Continued From page 12
This REQUIREMENT is not met as evidenced
by:
Based on observation and interview the facility
failed ensure garbage and refuse were properly
disposed of.

The findings included:

Observation of the facility's dumpsters on May
23, 2011, at 12:30 p.m., with the Dietary Manager
(DM), revealed the dumpster area with scattered
refuse including: three disposable latex gloves,
six plastic straws, three plastic cups, two candy
wrappers, two used sweetener packets, and
plastic utensils (a fork and knife) on the ground
surrounding the dumpster.

Interview with the DM, at the time of the
observation, confirmed the dumpster area was
not clean and well maintained.

F 386 483.40(b) PHYSICIAN VISITS - REVIEW
SS=E CARE/NOTES/ORDERS

The physician must review the resident's total
program of care, including medications and
treatments, at each visit required by paragraph (c)
of this section; write, sign, and date progress
notes at each visit; and sign and date all orders
with the exception of influenza and pneumococcal
polysaccharide vaccines, which may be
administered per physician-approved facility
policy after an assessment for contraindications.

This REQUIREMENT is not met as evidenced
by:

Based on medical record review and interview,
the physician failed to date the May 2011,

F 372

F372

HOW WILL CORRECTIVE ACTION
BE ACCOMPLISHED FOR THOSE
RESIDENTS FOUND TO HAVE
BEEN AFFECTED BY THE
DEFICIENT PRACTICE?

The debris around the Dumpster was
removed and is currently debris free.

HOW WILL THE FACILITY
IDENTIFY OTHER RESIDENTS
HAVING THE POTENTIAL TO BE
AFFECTED BY THE SAME
DEFICIENT PRACTICE?

The Dumpsters are at risk for this
practice.

F 386

WHAT MEASURES WILL BE PUT
INTO PLACE OR SYSTEMIC
CHANGES MADE TO ENSURE
THAT THE DEFICIENT PRACTICE
WILL NOT RECUR?

The dietary staff was in-serviced on May
31, 2011 and June 3, 2011 by the Dietary
manager regarding the need to ensure the
areas around the dumpster remains picked
up and free of debris.

The Dietary staff will make observations
of the area around the dumpsters at a
minimum of 3 times a day (M-F) to
ensure the area remains free of debris.

6/24/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/25/2011
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F 372	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed ensure garbage and refuse were properly disposed of. The findings included: Observation of the facility's dumpsters on May 23, 2011, at 12:30 p.m., with the Dietary Manager (DM), revealed the dumpster area with scattered refuse including: three disposable latex gloves, six plastic straws, three plastic cups, two candy wrappers, two used sweetener packets, and plastic utensils (a fork and knife) on the ground surrounding the dumpster. Interview with the DM, at the time of the observation, confirmed the dumpster area was not clean and well maintained.	F 372	An audit log of the dumpster's observation has been implemented to provide documentation of areas being free of debris. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? Results of the dumpster audit log will be presented to the QAA committee monthly for 3 months, if identified issues are noted then modifications will be made to this plan of correction.	
F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the physician failed to date the May 2011,	F 386		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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ANDERSONVILLE, TN 37705

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F 372	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed ensure garbage and refuse were properly disposed of. The findings included: Observation of the facility's dumpsters on May 23, 2011, at 12:30 p.m., with the Dietary Manager (DM), revealed the dumpster area with scattered refuse including: three disposable latex gloves, six plastic straws, three plastic cups, two candy wrappers, two used sweetener packets, and plastic utensils (a fork and knife) on the ground surrounding the dumpster. Interview with the DM, at the time of the observation, confirmed the dumpster area was not clean and well maintained.	F 372		
F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the physician failed to date the May 2011,	F 386	F386 HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? Residents # 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 13, 14 and #15 have had June Monthly MD order Recaps completed and these all include the MD signature and date. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? All MD orders are at risk for this practice.	6/24/11

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/25/2011
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NORRIS HEALTH AND REHABILITATION CENTER

3382 ANDERSONVILLE HIGHWAY
ANDERSONVILLE, TN 37705

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F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the physician failed to date the May 2011,	F 386	The Medical Records Director was in-serviced by the Administrator on June 6, 2011 to observe the physician and physician extender orders to determine if dates are being applied to their orders. If issues involving not dating the orders are observed then immediately make the administrator aware so interventions can be made to ensure the dates get applied to orders. The Medical Records Director will randomly audit the monthly recap sheets	

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F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the physician failed to date the May 2011,	F 386	to determine if dates are occurring each month for these medical orders monthly. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? Results of the monthly medical recap orders audit will be presented to the monthly QAA committee for 3 months. If identified issues are observed then the QAA committee including the medical director will discuss the issues and make recommendations for the issues to be resolved. Modifications to this plan of correct will occur if the QAA committee deems necessary.	

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F 386	Continued From page 13 monthly physician's recapitulation orders when signed for thirteen (#1, #2, #3, #4, #6, #7, #8, #9, #10, #11, #13, #14, and #15) of nineteen residents reviewed. The findings included: Medical record review of the May 2011, physician's recapitulation orders for residents #1, #2, #3, #4, #6, #7, #8, #9, #10, #11, #13, #14, and #15, revealed the recapitulation orders were signed by the physician. Continued review of the May 2011, physician's recapitulation orders revealed no date documented indicating when the physician's orders were signed. Interview on May 25, 2011, at 10:30 a.m., with the Director of Nursing, at the nursing station, confirmed the physician's signature was not dated when signed for the May 2011, physician's recapitulation orders for residents #1, #2, #3, #4, #6, #7, #8, #9, #10, #11, #13, #14, and #15.	F 386		
F 511 SS=D	483.75(k)(2)(ii) RADIOLOGY FINDINGS-PROMPTLY NOTIFY PHYSICIAN The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to promptly notify the physician or nurse practitioner of the results of a chest x-ray for one (#1) of nineteen residents reviewed. The findings included:	F 511	F511 HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? The Chest R-ray was reported to the physician. No other interventions can be made at this time for this issue.	6/24/11

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F 386 Continued From page 13

monthly physician's recapitulation orders when signed for thirteen (#1, #2, #3, #4, #6, #7, #8, #9, #10, #11, #13, #14, and #15) of nineteen residents reviewed.

The findings included:

Medical record review of the May 2011, physician's recapitulation orders for residents #1, #2, #3, #4, #6, #7, #8, #9, #10, #11, #13, #14, and #15, revealed the recapitulation orders were signed by the physician. Continued review of the May 2011, physician's recapitulation orders revealed no date documented indicating when the physician's orders were signed.

Interview on May 25, 2011, at 10:30 a.m., with the Director of Nursing, at the nursing station, confirmed the physician's signature was not dated when signed for the May 2011, physician's recapitulation orders for residents #1, #2, #3, #4, #6, #7, #8, #9, #10, #11, #13, #14, and #15.

F 511 483.75(k)(2)(ii) RADIOLOGY
SS=D FINDINGS-PROMPTLY NOTIFY PHYSICIAN

The facility must promptly notify the attending physician of the findings.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to promptly notify the physician or nurse practitioner of the results of a chest x-ray for one (#1) of nineteen residents reviewed.

The findings included:

F 386

HOW WILL THE FACILITY
IDENTIFY OTHER RESIDENTS
HAVING THE POTENTIAL TO BE
AFFECTED BY THE SAME
DEFICIENT PRACTICE?

Residents with radiology orders are at risk for this issue.

WHAT MEASURES WILL BE PUT
INTO PLACE OR SYSTEMIC
CHANGES MADE TO ENSURE
THAT THE DEFICIENT PRACTICE
WILL NOT RECUR?

The Licensed Nurses were in-serviced on June 1-2, 2011 and on-going until all have completed the in-service education, regarding the need to include new orders to the 24 Hour Nursing report so follow up can take place that include reporting results of such services.

F 511

During the Daily clinical Meeting the 24 Hour nursing report (M-F) will be reviewed by the DON, ADON and Unit Managers to ensure follow up on medical procedures have taken place including MD notification.

Copies of medical procedures including labs, x-rays will also be placed on the physician communication board.

An audit of 5 random medical procedures will be reviewed from the new Telephone Orders/24 Hr Nursing report weekly for 4 weeks then monthly for 2 months. If identified issues are noted then

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F 511	<p>Continued From page 14</p> <p>Resident #1 was admitted to the facility on December 31, 2010, and readmitted on April 18, 2011, with diagnoses including Gastrointestinal Hemorrhage, Dementia, Anemia, Osteoporosis, and Right Hip Fracture.</p> <p>Medical record review of a nursing note dated May 17, 2011, at 12:00 p.m., revealed "Resident noted to have congestion in BLU & L (bilateral upper and lower) lung fields per auscultation. A deep wet cough, NP (nurse practitioner) notified new orders."</p> <p>Medical record review of a NP's order dated May 17, 2011, revealed "CXR (chest x-ray) to r/o (rule out) pneumonia..."</p> <p>Medical record review of a chest x-ray report dated May 17, 2011, and received by the facility on May 17, 2011, revealed "...Mild patchy left basilar density compatible with pneumonia..."</p> <p>Medical record review revealed no documentation the physician or NP was notified of the chest x-ray results until May 20, 2011.</p> <p>Medical record review of a NP's order dated May 20, 2011, revealed "Levaquin (antibiotic) 500 mg (milligrams) po (by mouth) daily X (times) 10 d (days) for pneumonia."</p> <p>Interview on May 24, 2011, at 1:05 p.m., with the Director of Nursing, in the Administrator's office, revealed the x-ray results were to be reported to the NP/physician as soon as possible, and confirmed the three day delay in notifying the NP/physician.</p>	F 511	<p>appropriate interventions and in-service education will be repeated for the involved nurse.</p> <p>HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>Results of the random audits will be presented to the QAA committee monthly for 3 months. If identified issues are noted then the QAA committee will make recommendations for additional corrections and the audits will continue until committee feels this issue is resolved.</p>	